

Benefits	Blue Traditional	Blue Cross Community Blue	Blue Care Network HMO and Medicare Advantage	Health Alliance Plan HMO and Senior Plus Plan
<b>Surgical Services</b>				
Surgery – includes related surgical services	Approved amount, may require precertification/second opinion	Covered – 100%	Covered – 100%	Covered – 100%
Sterilization	Covered when medically necessary	Covered – 90%, after deductible and copay	Covered – 100%	Covered – 100%
LASIK Surgery	Not covered	Not covered	Not covered	Not covered
Human Organ Transplant Procedures	\$1,000,000 lifetime maximum for heart, heart/lung, pancreas and liver. Bone marrow, cornea, kidney and skin covered at reasonable charges, coordinated through BCBSM Human Organ Transplant Program at 1-800-242-3504	Covered – 100% in designated facilities only, coordinated through BCBSM Human Organ Transplant Program at 1-800-242-3504, \$1,000,000 lifetime maximum per transplant for heart, heart/lung, pancreas and liver.	Covered when coordinated through Primary Care Physician (except experimental) and authorized by BCN	Covered (except experimental)
<b>Emergency Care — Medical</b>				
Hospital and Physician Services	Hospital: Covered – \$75 copay for hospital emergency room, waived if admitted or accidental injury  Physician: 80% under MM after deductible and copay	Covered – \$75 copay for hospital emergency room, waived if admitted or accidental injury	Covered – \$75 copay for hospital emergency room, waived if admitted  Medicare Advantage Only: \$50 copay for hospital emergency room, waived if admitted	Covered – \$75 copay for hospital emergency room, waived if admitted  Senior Plus Plan Only: \$50 copay for hospital emergency room, waived if admitted
Urgent Care Facility	Covered – 80% after deductible and copay	Covered – 100%, \$10 copay	Covered – \$10 copay	Covered – \$10 copay per visit
Ambulance – medically necessary	Covered – 80% under MM after deductible and copay	Covered – 100%	Covered – 100%	Covered – 100%
<b>Emergency Care — Accidents</b>				
Hospital Emergency Room – approved diagnosis	Covered – \$75 copay for hospital emergency room, waived if admitted or accidental injury. Treatment with follow-up care at 80% under MM after deductible and copay	Covered – \$75 copay for hospital emergency room, waived if admitted or accidental injury	Covered – \$75 copay for hospital emergency room, waived if admitted  Medicare Advantage Only: \$50 copay for hospital emergency room, waived if admitted	Covered – \$75 copay for hospital emergency room, waived if admitted  Senior Plus Plan Only: \$50 copay for hospital emergency room, waived if admitted
Urgent Care Facility	Covered – 80% after deductible and copay	Covered – 100%, \$10 copay	Covered – \$10 copay	Covered – \$10 copay per visit
Ambulance Services – medically necessary	Covered – 80% under MM after deductible and copay	Covered – 100%	Covered – 100%	Covered – 100%

# Retiree Medical Plans Benefits Summary

Benefits	Blue Traditional	Blue Cross Community Blue	Blue Care Network HMO and Medicare Advantage	Health Alliance Plan HMO and Senior Plus Plan
<b>Maternity Services Provided by a Physician</b>				
Outpatient Pre-Natal and Post-Natal Care	Covered – 100%	Covered – 100%, includes care provided by a certified nurse midwife	Covered – \$10 copay	Covered – 100%
Delivery in hospital	Covered – 100%, includes delivery provided by a certified nurse midwife	Covered – 100%, includes delivery provided by a certified nurse midwife	Covered – 100%	Covered – 100%
Newborn Baby Care in hospital	Covered – 100%	Covered – 100%, includes care provided by a certified nurse midwife	Covered – 100%	Covered – 100%
<b>Prescription Drugs</b>				
Prescription Drugs (Including birth control pills)	\$5 generic/\$15 brand name copay, excluding contraceptives	\$10 generic/\$20 brand name copay	Covered with \$5 generic/\$15 brand name copay, (including diabetic supplies and contraceptives)	Covered with \$5 generic/\$15 brand name copay
Mail Order	Covered with \$10 generic/\$30 brand name prescription copay (90 day supply)	\$20 generic/\$40 brand name copay (90 day supply)	Covered with \$10 generic/\$30 brand name prescription copay (90 day supply)	Covered with \$10 generic/\$30 brand name prescription copay for a 90 day supply
<b>Diagnostic and Therapeutic Services – Outpatient</b>				
Laboratory and Pathology Tests	Covered – 100% of approved amount when services performed by a participating provider	Covered – 90% after deductible and copay when services performed by a participating provider	Covered – 100%	Covered – 100%
Diagnostic Tests and X-rays	Covered – 100% of approved amount when services performed by a participating provider	Covered – 90% after deductible and copay when services performed by a participating provider	Covered – 100%	Covered – 100%
Radiation Therapy	Covered – 100% of approved amount when services performed by a participating provider	Covered – 90% after deductible and copay when services performed by a participating provider	Covered – 100%	Covered – 100%
<b>Alternatives to Hospital Care</b>				
Skilled Nursing Care in a nursing home	Twice the amount of unused hospital days, maximum 730 days for general conditions and 90 days for mental health care (excludes custodial care)*	Covered – 100%, up to 120 days*	Covered – 100% up to 730 days*	Covered up to 730 days*, renewable after 60 days
Skilled Nursing Care in a residential home	Covered in full when services performed by a participating home health care agency, 50% under MM for Private Duty Nursing, 80% under MM for Visiting Nurse*	Covered – 100% when medically necessary*	Covered – 100% when authorized by BCN*	Covered – 100%* for authorized services by a RN or LPN
Home Health Care	Covered in full when services performed by a participating home health care agency*	Covered – 100% when performed by a participating provider*	Covered – \$10 copay when authorized by BCN*	Covered – 100% for authorized services by a RN or LPN
Custodial Care	Not covered	Not covered	Not covered	Not covered
Hospice Care	Covered – 100% when services performed by a participating provider*	Covered – 100% when services performed by a participating provider*	Covered – 100% with a participating provider*	Covered – 100%, 210 days/lifetime Senior Plus Plan Only: Not covered, covered under

Benefits	Blue Traditional	Blue Cross Community Blue	Blue Care Network HMO and Medicare Advantage	Health Alliance Plan HMO and Senior Plus Plan
<b>Mental Health Care</b>				
Outpatient Psychiatric Hospital Services	First 6 visits paid at 100% under Basic, then 50% under MM after deductible and copay*	Covered – 50% copay*	Covered – \$10 copay per visit, 20 visits per calendar year*	Covered – \$10 copay per visit for 20 visits per calendar year
			Medicare Advantage Only: Covered – 100%, unlimited visits	Senior Plus Plan Only: Covered – 100%, unlimited days according to Medicare guidelines
Inpatient Psychiatric Hospital Services	Approved amount for up to 45 days under basic, then 50% under MM after deductible and copay*	Covered – 50% copay unlimited days*	Covered – 45 days per calendar year, renewable after 60 days out*	45 days, renewable after 60 days
			Medicare Advantage Only: Covered – 100%, up to 190 days Medicare lifetime maximum. Additional 45 days per episode of illness after Medicare benefit is exhausted and 60 consecutive days have elapsed from last date of discharge. Then 45 days renewable after 60 days out between admissions.	Senior Plus Plan Only: Covered – 100%, unlimited days according to Medicare guidelines
<b>Alcoholism and Drug Abuse</b>				
Outpatient Alcoholism and Drug Abuse	35 visits per member per year; not less than mandated annual maximum in an outpatient facility*	Covered – 50% copay up to the state-dollar amount which is adjusted annually*	Covered – \$10 copay per visit, 20 visits per calendar year or state mandated annual aggregate dollar amount, whichever is greater*	Covered – \$10 copay per visit. A 35 visit limit per calendar year or state mandated annual aggregate dollar amount, whichever is greater
			Medicare Advantage Only: Covered – 100%, unlimited visits	Senior Plus Plan Only: Covered – 100%, unlimited days according to Medicare guidelines
Inpatient Alcoholism and Drug Abuse	Approved amount for 45 days under basic, charged against mental health in hospital residential program. Mandated annual maximum in a nonhospital residential program*	Covered – 50% copay unlimited days*	Covered – 100%, one program of treatment per any 12 month period*	45 days, renewable after 60 days of state mandated annual aggregate dollar amount, whichever is greater
			Medicare Advantage Only: Covered – 100%, unlimited days	Senior Plus Plan Only: Covered – 100%, unlimited days according to Medicare guidelines
<b>Appliances &amp; Prosthetic Devices (Leg Braces, Artificial Limbs, etc.)</b>				
When Medically Necessary	Covered – 80% under MM after deductible and copay	Covered – 90% after deductible and copay	Covered – 100%	Covered – 100%
When Body's Growth or Development Necessitates Replacement	Covered – 80% under MM after deductible and copay	Covered – 90% after deductible and copay	Covered – 100%	Covered – 100%
Normal Wear and Damage	Covered – 80% under MM after deductible and copay for normal wear and damage subject to medical review	Covered – 90% after deductible and copay for damage; not covered for normal wear	Covered – 100% for normal wear; not covered for damage	Covered – 100%
Durable Medical Equipment (Wheelchairs, Bedding, Crutches, etc.)	Covered – 80% under MM after deductible and copay	Covered – 90% after deductible and copay	Covered – 100%*	Covered – 100% Page 3 of 31

# Retiree Medical Plans Benefits Summary

Benefits	Blue Traditional	Blue Cross Community Blue	Blue Care Network HMO and Medicare Advantage	Health Alliance Plan HMO and Senior Plus Plan
<b>Vision Services</b>				
Vision screening	Covered under separate plan	Covered under separate plan	Covered – 100%*	Covered – 100%
Eye refractions	Covered under separate plan	Covered under separate plan	Covered under separate plan	Covered – 100%
Corrective Lenses	Covered under separate plan	Covered under separate plan	Covered under separate plan	Covered under separate plan
<b>Hearing Services</b>				
Hearing Screening	Not covered	Not covered	Covered – \$10 copay	Covered – 100%
Hearing Examination	Not covered	Not covered	Covered – 100%, one exam every 36 months	Covered – 100%
Hearing Aids	Not covered	Not covered	Covered – 100% one aid every 36 months*	Covered – 100% for authorized, conventional hearing aids
<b>Dental Services</b>				
Examinations and Fillings	Covered under separate plan	Covered under separate plan	Covered under separate plan	Not covered
Accident-related or multiple extractions in hospital with concurrent medical condition	Accident related: 80% payable under MM after deductible for services rendered by a dentist, also covers prosthetic appliances. Multiple extractions in a hospital with a concurrent medical condition, approved amount under basic.*	Covered – 100%	Covered – 100% for prompt emergency treatment for accidental injury to sound, natural teeth	Covered – 100% for prompt emergency treatment for accidental injury to sound, natural teeth
Periodontic Surgery	Covered under separate plan	Covered under separate plan	Covered under separate plan	Not covered
Impacted Wisdom Teeth	Covered under separate plan	Covered under separate plan	Covered under separate plan	Not covered
<b>Chiropractic Services</b>				
Manipulations or adjustments; diagnostic radiological services; evaluation and treatment	20 visits covered during first 90 days for acute conditions. Two visits per month, thereafter, for the same chronic condition under MM after deductible and copay.	Covered – 100%, \$10 copay up to 24 visits per year	Covered – \$10 copay only if referred by Primary Care Physician	Not covered  Senior Plus Plan Only: Covered
<b>Other Services</b>				
Outpatient Physical, Speech and Occupational Therapy	Covered – 100% restrictions apply*	Covered – 90% after deductible and copay up to 60 visits per calendar year, not payable in a physician's office, restrictions apply*	Covered – \$10 copay; limited to 60 consecutive days per episode for a combination of therapies when authorized by BCN*	Covered – up to 60 visits per condition-lifetime  Medicare Advantage Only: Covered – \$10 copay, unlimited visits  Senior Plus Plan Only: Covered – 100%, unlimited days according to Medicare guidelines
Private Duty Nursing	Covered – 50% copay	Covered – 50% copay	Covered only when authorized by BCN*	Not covered

\*Certain criteria must be met. For specific guideline information, please contact Customer Service.

Benefits	Blue Traditional	Blue Cross Community Blue	Blue Care Network HMO and Medicare Advantage	Health Alliance Plan HMO and Senior Plus Plan
<b>MISCELLANEOUS</b>				
Major Medical/Deductible	\$175 per person \$350 per family	<u>In-network:</u> \$175 per person \$350 per family  <u>Dut-of-network:</u> \$425 per person \$850 per family	None	None
Major Medical Copayment	Paid at 100% – Extended hospital services 80% general services 50% private duty nursing and outpatient psychiatric treatment	\$10 office visit copay \$75 emergency room copay, waived if admitted or accidental injury	\$10 office visit copay \$75 emergency room copay per visit, waived if admitted; \$10 outpatient mental health/substance abuse copay per visit \$10 urgent care copay  Medicare Advantage Only: \$10 office visit copay \$50 emergency room copay per visit, waived if admitted; \$10 urgent care copay	None
<u>In-Network:</u> Annual copayment maximum (does not include deductible or fixed copayment requirements)	\$825 per person \$1650 per family (only applies to MM benefits)	\$825 per person \$1650 per family	N/A	N/A
<u>Dut-of-Network:</u> Annual copayment maximum (does not include deductible or fixed copayment requirements)	N/A	\$1575 per person \$3150 per family	N/A	N/A
Conversion Option	Yes	Yes	Yes	Yes
Claim Forms	Basic Service – No	No	No	No
Major Medical	Yes	No	No	No
Worldwide Coverage (Emergency care only)	Yes	Yes	Yes	Yes
Coverage for incapacitated children	Yes	Yes	Yes	Yes

## EXHIBIT 10

2ND DRAFT

# MASTER AGREEMENT

BETWEEN THE

## CITY OF DETROIT

AND

**MICHIGAN COUNCIL 25**  
**OF THE AMERICAN FEDERATION OF STATE COUNTY AND**  
**MUNICIPAL EMPLOYEES, AFL-CIO**  
**(NON-SUPERVISORY BARGAINING UNIT)**

**July 1, 2005 - June 30, 2008**

DRAFT 10/24/2006

## **32. JURY DUTY**

- A. An employee who serves on jury duty will be paid the difference between his/her pay for jury duty and his/her regular pay for all days he/she is required to serve on jury duty.
- B. In the event that an employee reports for jury duty but does not actually serve on a jury, he/she will be paid the difference between the jury pay received and his/her regular days pay and be excused for the day.
- C. In order to receive payment for jury duty supplementation, an employee must have been regularly scheduled to work on a non-overtime basis, must give reasonably prompt prior notice to his/her supervisor that he/she has been summoned for jury duty, and must furnish satisfactory evidence that he/she reported for or performed jury duty on the days for which he/she claims such payment, provided that the department head shall have discretion in seeking to have the employee excused where his/her services are essential.

The jury duty supplementation shall not apply to special service, contractual, temporary or other employees with less than one year of seniority.

- D. When properly notified by an employee under the terms of Section C, the department shall, if necessary, reschedule the work assignment of the employee so as to coincide as closely as possible with the jury duty schedule. This reassignment shall take precedence over other conflicting sections of this contract (except Article 7-F).
- E. Employees shall have the option when called to jury duty to use vacation or compensatory time for such service. In that event, the employee will not be required to turn in his/her jury pay. However, the employee must notify the department of his/her desire to exercise this option prior to the first date of jury service.
- F. Jury duty shall be considered as time worked.

An employee on jury duty will be continued on the payroll and be paid at his/her straight time hourly rate for his/her normally scheduled hours of work.

## **33. HOSPITALIZATION, MEDICAL, DENTAL AND OPTICAL CARE INSURANCE**

*The parties have reached an agreement in regard to health care plan changes in accordance with the MOU Re: Concession Agreement. However, the hospitalization, medical, dental and optical care benefits as of June 30, 2005, will be maintained until the new care design plan changes are implemented. That implementation is to occur on or after July 17, 2006. Changes to this article are reflected in the Memorandum of Understanding RE: Alternative Health Care Plan.*

- A. The City shall continue to provide hospitalization and medical insurance based on the Blue Cross/Blue Shield ward service rate under the Michigan Variable Fee Coverage (MVF-2) and the Prescription Drug Group Benefit Certificate with two dollar (\$2) co-pay

(Certificate #87)<sup>1</sup>, known as the two dollar (\$2) deductible Drug Rider for employees and their legal dependents, duty disability retirees and their legal dependents, and duty death beneficiaries and their legal dependents, as provided by Chapter 13, Article 8 of the Municipal Code of the City of Detroit.

- B. The City's contribution for the cost of hospitalization on a monthly basis shall be as follows:

<b>Single person</b>	<b>\$100.06</b>
<b>Two person</b>	<b>\$238.29</b>
<b>Family</b>	<b>\$253.54</b>

Fifty percent of any premium charges that exceed the above amounts will be paid by the employees and fifty percent shall be paid by the employer. When the City's payroll system has the capability of allowing employees to pay these amounts through the pre-tax IRS code 125K mechanism, all bargaining unit members shall be entitled to participate.

- C. Employees who wish to insure sponsored dependents shall pay the premium cost of this coverage.
- D. The City will pay the premium for regular retirees and their spouses hospitalization and medical insurance based on the Blue Cross/Blue Shield ward service under the Michigan Variable Fee coverage (MVF-2) and the Prescription Drug Group Benefit Certificate with two dollar (\$2) co-pay (Certificate #87)<sup>1</sup> known as the two dollar (\$2) deductible Drug Rider as provided by City Council in the 1977-78 Closing Resolution. The city will pay this premium for regular retirees and their spouses for only as long as they receive a pension from the City.

For persons who retire (except for vested retirees) on or after July 1, 1986, the City will pay the following amounts per month for hospitalization and medical insurance:

<b>Single person</b>	<b>\$100.06</b>
<b>Two person</b>	<b>\$238.29</b>

Fifty percent of any increase over these amounts will be paid by the retiree. The City will pay this premium for regular retirees and their spouses only for as long as they receive a pension from the City.

- E. The City Blue Cross hospitalization plan for active employees and their dependents shall include Blue Cross Master Medical insurance with a twenty percent (20%) co-pay benefit and a fifty dollar (\$50) per person annual deductible (\$100 for two or more in a family).
- F. Employees and retirees shall have the option of choosing alternative hospitalization medical coverage from any plan or program made available by the City. The City's contribution to the alternative plans or programs shall be limited to the premium cost for

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<sup>1</sup> The \$2 deductible Drug Rider (Certificate #87 as referenced above, reflects the benefit at the time the premium sharing arrangement was instituted. Currently, the co-pay for the Prescription Drug benefit is \$3. Retirees shall be responsible for the co-pay amount in effect at the time of retirement.

the level of benefits provided in Paragraphs B and D, as applicable. If at the end of any fiscal year an alternative hospitalization plan or program has failed to enroll 50 employees city-wide, the City shall have the option of removing that plan from the list of eligible plans or programs. Effective with the 1987-88 fiscal year, all alternate carriers must account for their premium charges without distinguishing between active and retired employees using the following format:

<b>Single Person</b>
<b>Two Persons</b>
<b>Family</b>

- G. The City shall provide for all active employees and their dependents, and duty disability retirees and their dependents, a Dental Plan which shall be the Blue Cross/Blue Shield program which provides Class I benefits on a 25% co-pay basis and Class II and III benefits on a 50% co-pay basis. Classes I, II, and III benefits shall not exceed \$1,000 per person per year. In addition, Orthodontic coverage shall be on a 50% co-pay basis with a \$1,000 lift time maximum. Other terms and conditions regarding these plans shall be in accordance with the standard Blue Cross/Blue Shield policies regarding administration of such programs.

The City, in mutual agreement with the Union and the Health Care Cost Reductions Committee (HCCRC), will make available cost effective alternative dental plans.

Newly hired employees shall not be eligible for these benefits until they shall have worked 1,040 straight time hours.

- H. The City will provide Optical Care Insurance through the Employee Benefit Board according to the schedule of benefits outlined in Exhibit II. Effective July 1, 1999, through June 30, 2001, the City will contribute \$5.50 per month for employees covered by CO/OP Optical and \$5.43 per month for employees covered by Heritage Optical.

Optical care enrollments will occur at two (2) year intervals.

- I. If, during the term of this Agreement, a Federal Health Security Act (National Health Insurance) is enacted, the parties agree to reopen discussions with respect to health care benefits if there is need to do so due to the impact of such a Federal program.
- J. No insurance carrier shall be allowed to underwrite City Health Care Benefits unless it offers coordination of benefits. All carriers will be required to provide group specific utilization and cost data as a condition of doing business with the City. Copies of all information will be provided to Union and City representatives as directed.
- K. The parties agree to form a Health Care Cost Containment Committee made up of an equal number of members from the City and the Union which will review and agree to further cost containment programs to cover both active employees and future retirees during the term of the Contract. Said cost containment programs shall not diminish the levels of benefits provided in the basic plans but may require the insured to follow procedures prescribed by the carrier in order to be eligible for benefits. If premium levels remain below the amounts listed in the 1982-83 base premium levels for insurance listed in

paragraph "B", the City will pay fifty percent (50%) of that amount to an escrow account which shall be used to offset health care costs or increase health care benefits.

Furthermore, the parties agree during the term of this Agreement to continue to discuss the City's hospitalization plans. The parties are committed to investigate programs which will reduce costs and bring about a corresponding reduction in premium sharing by employees. Programs to be considered would include alternative health care providers, additional cost containment programs, and alternative traditional plans. Any programs agreed to by the parties will be implemented during the term of this Agreement.

- L. **HOSPITALIZATION-MEDICAL COVERAGE OPT-OUT PROGRAM:** Effective July 1, 1999, employees on the active payroll who are covered by a health care plan offered by an employer other than the City, and can furnish proof of such coverage, may elect to take an annual \$950 cash payment, which will be paid in four (4) equal installments (\$237.50) at the end of each three (3) month period, in lieu of the hospitalization-medical coverage offered by the City. This election shall take place annually during the open enrollment period.

Once an employee elects the cash payment, the employee will not receive hospitalization-medical coverage until the next year's enrollment period. If the employee loses his eligibility for the alternate coverage, the employee, upon submitting appropriate proof of loss of coverage, will be able to resume the City's hospitalization-medical coverage the month following completion of the applicable enrollment forms. The cash payments will cease upon the employee resuming the City's hospitalization-medical coverage.

The City shall have the sole discretion to offer this opt-out provision to current and future retirees who are eligible for the City's hospitalization-medical coverage. This discretion shall extend to the determination of the amount of the cash payment, the method of payment, the eligibility requirements, and the continuance of the opt-out plan itself.

**Note:** A description of the City's health care, optical and dental plans appear in Exhibit II.

## **34. WORKERS' COMPENSATION**

- A. All employees shall be covered by the applicable Workers' Compensation laws and related benefits. An employee sustaining injury or occupational disease arising out of and in the course of City employment shall be continued on the payroll and his/her time shall be charged to his/her sick leave reserve for all days not covered by Workers' Compensation payments; provided that in the absence of any sick leave reserve he/she shall be paid regular wages or salary to the extent of two-thirds of his/her daily wage or salary but for a period not to exceed seven (7) days; provided also that where the employee has off-time banks and receives income under the Workers' Compensation Act, such income shall be supplemented by the City from his/her off-time banks in an amount sufficient to bring it up to ninety-five percent (95%) of his/her weekly take-home pay. For the purposes of this Article, take-home pay is defined as gross pay from the City less Social Security deductions, and less Federal, State and City income tax withholding amounts based on the employee's actual number of dependents. Employees shall be eligible to earn current sick leave.

## **EXHIBIT II**

CITY OF DETROIT  
AFSCME MICHIGAN COUNCIL 25  
NON-SUPERVISORY BARGAINING UNIT

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### **RE: HEALTH CARE PLANS**

#### **INTRODUCTION**

The City of Detroit offers a traditional hospitalization plan for employees and retirees plus they may choose alternative coverage through one of the health maintenance organizations or preferred provider plans offered by the City. A list of the City's current hospitalization carriers and coverage descriptions is contained herein.

Furthermore, the traditional health plan described herein includes several cost containment features. Furthermore, the joint union/management health cost containment committee will be studying additional cost containment programs which will be included during the term of the agreement.

**Note:** This matter may also be referred to the Central Labor/Management Committee by mutual agreement of the parties, (see Memorandum of Understanding, page 93).

#### **ELIGIBILITY**

**Note:** This summary of health insurance plans described herein contain the essential features of the hospitalization insurance plans offered by the City in general terms. It is not intended to be a full description of coverage. The complete plans are described in the certificate of coverage issued by each plan.

##### **A. PERSONS ELIGIBLE FOR HEALTH CARE COVERAGE:**

1. The employee;
2. The employee's dependents as explained below:

The legal spouse of the subscriber, unmarried children related by birth, legal adoption, or legal guardianship (while a dependent of the subscriber), and children of the subscriber's spouse (while a dependent of the subscriber). These children are covered from birth to the end of the calendar year in which they attain 19 years of age. This limit shall be extended one more year for those children still in high school.

Unmarried, dependent children who are incapable of self-support because of a permanent mental or physical disability are eligible for coverage. An application card, which contains a "physician's certification of disability", must be submitted before December 31<sup>st</sup> of the year in which the dependent becomes 19 years of age.

Nineteen to twenty-five year old dependents continue to be covered until the end of the calendar year in which they attain 25 years of age as long as they are unmarried, enrolled in an accredited school as a full-time student, and are dependent upon the employee for support and maintenance and were reported as such on the employee's most recent federal income tax return. There will be no additional charges for this coverage when they are under an employee contract.

Under the "Consolidate Omnibus Budget Reconciliation Act of 1985 (COBRA)", employees and their eligible dependents will have the option to continue group health coverage at their own expense after that coverage would have normally terminated. This option becomes available upon certain qualifying events that occur on or after July 1, 1986. Group health coverage includes hospitalization, dental and eye care coverage as one complete package.

**B. QUALIFYING EVENTS AFFECTING EMPLOYEES:**

1. The reduction of work hours or a temporary layoff that causes employees to lose their group coverage.
2. Termination of employment, either voluntary or involuntary (except for termination for gross misconduct).

Employees may elect to continue their group health coverage up to 18 months beyond the qualifying event in 1 or 2 above. (The full monthly premium cost must be paid each month to continue coverage).

**C. QUALIFYING EVENTS FOR EMPLOYEES BENEFICIARIES:**

1. Upon divorce or legal separation of employee and the employee's spouse (spouse option to include the dependent children).
2. The date a dependent child no longer qualifies as a dependent under the plan. (example, dependent child passes the maximum age for coverage as a dependent child).
3. Upon the death of the employee.
4. Upon the employee becoming entitled to benefits under Title XVIII of the Social Security Act (and the spouse and dependent children lose the employer provided group health coverage).

The employee's spouse and dependent children may elect to continue the same group coverage up to 36 months from the date of the qualifying event noted in 1, 2, 3, or 4 above. The full monthly premium cost must be paid each month to continue coverage.

**D. CANCELLATION OF COVERAGE:**

Continuation of coverage will be canceled upon the occurrence of the following circumstances:

1. Cancellation of group health plan to active employees.
2. The qualified beneficiary becomes a covered employee under another group health plan or becomes entitled to Medicare benefits.
3. The qualified beneficiary fails to pay the required premium.

4. The qualified beneficiary remarries and becomes covered under a group health plan.
5. The end of the continuation coverage period.

**E. EFFECTIVE DATES FOR HOSPITALIZATION COVERAGE:**

1. **Coverage Period:** First (1<sup>st</sup>) through thirty-first (31<sup>st</sup>).
2. **Qualifying for Continuing Coverage:** Any month in which an employee receives a paycheck with at least eight (8) hours of pay, he/she will have coverage for the entire month; less than eight (8) hours of pay – no coverage.

**Note:** Suspensions and Departmental Leave are governed by this section.

3. **Coverage Effective Date:** For new hires or employees returning from Human Resources leaves or layoffs, coverages are effective the day they receive their first paycheck.

**Note:** For new or returning employees, coverage dates will be determined as of the date the employee would have normally received his/her paycheck

4. **Coverage Ending Date:** End of the month in which an employee receives the last paycheck. Lump-sum payments or special-pay adjustments, after an employee has left the payroll, do not continue hospitalization coverage.
5. Upon implementation of the new payroll system, coverage will begin on the first day of the first full payroll period, and ends on the last day of the month that employment ends.

## **SECTION 1**

### **TRADITIONAL HOSPITALIZATION**

**A. HOSPITAL CHARGES:**

The City's hospital benefits include the following:

- The cost (ward room and board rates) for 365 days for treatment of general conditions. (Employees may elect semi-private coverage at their own expenses).
- Renewal: Full benefits are restored after a consecutive period of 60 days has elapsed since the date of last discharge from a hospital.
- The cost of ward room and board for treatment of mental and nervous disorders is limited to forty-five (45) days. The full cost of ward room and board at a general hospital for treatment of substance abuse (alcohol and drug-related) disorders is limited to five (5) days. Up to forty days (40) of in-patient rehabilitation treatment shall be covered in a free standing facility that specializes in this type of treatment and is pre-approved by the plan. (If a member is admitted directly into non-hospital based facility, the maximum number of days will be forty-five [45]).

- Renewal: In order to re-establish hospital benefits for a nervous or mental disorder, there must be a period of non-confinement equal to at least sixty (60) consecutive days.
- See master medical section for additional benefits.

**B. MATERNITY BENEFITS:**

(applies to members of the plan)

Ward hospital room and board charges or birthing center charges and charges for other hospital services resulting from pregnancy, childbirth or miscarriage are covered in accordance with the plan.

**C. OTHER HOSPITAL SERVICES:**

The plan will pay the full cost of the items shown below when furnished by a hospital or its hospital staff and prescribed by your doctor.

- general nursing service
- special diets
- operating, delivery and treatment rooms and equipment
- anesthesia
- laboratory examinations
- physical therapy and oxygen or other gas therapy
- drugs and medicines
- supplies for dressings and plaster casts
- use of radium (when owned or rented by the hospital)
- routine nursery care for newborn children
- non-routine hospital care for newborn children

**D. EMERGENCY SERVICES:**

The plan will pay all charges in connection with emergency room treatment on non-occupational "accidental injuries" and life threatening "medical emergencies", following a \$75 employee co-pay. This \$75 co-payment will be waived if the employee is admitted into the hospital.

**E. PRE-ADMISSION CERTIFICATION:**

A Hospital Pre-Admission certification form MUST be completed and returned to the plan for approval before the plan will approve any elective non-emergency hospital admission. In order to receive hospital benefits paid for by the plan, in-patient non-emergency admissions MUST be prior authorized by the plan. An appeal process for the physician and member shall be a part of this plan.

Hospital Pre-Admission Certification forms will be available from the providers, physicians, the Plan Offices, and the employer and must be submitted to the plan before the proposed hospital admission.

An employee's doctor will complete the form and submit it to the plan. Both the employee and his/her doctor will receive notification regarding whether or not the admission has been approved.

In cases of emergency admittance to a hospital which shall include emergency admittance for alcohol and drug abuse, the hospital must notify Blue Cross within twenty-four (24) hours and they will certify the number of days allowable based upon the information submitted. If the attending physician requires a member to remain in the hospital for longer than the pre-certified amount of time, they must obtain approval from Blue Cross for additional days. Unless specifically approved, the plan will not pay for any days spent in a hospital beyond those approved by the pre-certification.

#### **F. AMBULATORY PROCEDURES REQUIREMENTS:**

All medical surgical procedures on the attached list must be performed on an ambulatory basis unless pre-certified by the Plan.

#### **G. EXTENDED CARE FACILITIES:**

If an employee or an eligible dependent are transferred to an extended care facility immediately following a home or hospital confinement (home health care status shall be considered as hospital confinement for purposes of this section), the plan will pay the full cost of room and board and other medical services. Pre-certification is required.

Extended care facility benefits are limited to a maximum of 730 days and are reduced by two (2) times the number of days spent in a hospital for the same condition.

#### **H. HOME HEALTH CARE AND HOSPICE CARE BENEFITS:**

The plan covers charges for the following home health care services:

1. Professional nursing care
2. Physical therapy
3. Speech therapy
4. Home health aide services
5. Expenses for equipment or materials used for home health care treatment (e.g., surgical dressings, oxygen, gauze, cotton, etc.).

(Three (3) home health care visits are equivalent to one (1) day of hospital care.)

Home hospice care is designed specifically for treatment of the terminally ill. Medical care concentrates on pain management and professional counseling for both patients and their families.

All home hospice services must be prior authorized (refer to the section entitled Pre-Admission Approval). Once approved, the plan pays the full cost of hospice care including nursing and other required medical services up to the plan limit.

#### **I. BILLING AUDITS:**

Employees are encouraged to review their hospital and doctor bills for accuracy.

## **MEDICAL SURGICAL BENEFITS**

#### **A. SURGICAL EXPENSE BENEFITS:**

If an employee or one of their eligible dependents must undergo surgery as the result of a non-occupational injury or illness, the plan will pay in full for all surgical procedures performed by a surgeon who has agreed to reasonable and customary charges established by the plan.

#### **B. SECOND SURGICAL OPINION:**

Mandatory second surgical opinions will be in accordance with the attached list of procedures (Does not apply to emergencies).

For all other procedures:

If a doctor has recommended elective (non-emergency) surgery, an employee must seek a second medical opinion before consenting to the surgery.

When employee seeks a second opinion the employee is required to obtain any x-rays or test results from the first physician and have them reviewed by second physician to avoid duplications of tests.

The plan covers doctor's reasonable and customary fees associated with a second surgical opinion.

In addition to payment for doctor's charges, the plan will also cover the cost of diagnostic laboratory and x-ray services performed in conjunction with the second surgical opinion.

If a member receives conflicting medical opinions regarding the need for a surgical procedure, the employee will make the final decision about whether or not to have the surgery. If the employee does decide to have the surgery, the plan will provide surgical benefits.

#### **C. MATERNITY BENEFITS:**

(applies to members of the plan)

Charges for outpatient care by member's doctor are eligible expenses under the plan.

**D. X-RAY AND LABORATORY SERVICES:**

If a member of the plan has x-ray and/or laboratory services related to a non-occupational illness or accident in a non-hospital setting, the charges are covered in full.

**E. MENTAL AND NERVOUS DISORDERS:**

Treatment for substance abuse, psychiatric and nervous disorders shall be limited to \$400 per member per calendar year for out-patient services.

**F. OTHER ITEMS COVERED BY THE PLAN:****Physician's Services**

- Medical Care of In-patients
  - Hospital
  - Convalescent Care Facility
  - Psychiatric Day/Night Care Hospital
  - Residential SAT program
- Surgery; Anesthesia; Surgical Assistant
  - Consultations
  - In-patient
- Maternity Care
  - Pre & Post Natal Visits
  - Delivery
  - Examination of Newborn
- Emergency Care
  - Injuries; Medical Conditions
- Psychiatric Care
  - In-patient
  - Out-patient \$400
- Chemotherapy
- Therapeutic Radiology
- Diagnostic Radiology
  - Routine Mammogram
- Diagnostic Lab & Pathology
  - Routine PAP Smear
  - PSA Testing
- Other Diagnostic Services
  - EKG: EEG: etc.

**G. ITEMS NOT COVERED BY HOSPITAL - MEDICAL - SURGICAL BENEFITS:**

The plan does not cover the following types of disabilities, expenses or care:

1. Dental care except for extractions or removal of unerupted teeth under general anesthesia when a concurrent hazardous medical condition exists;

2. Cosmetic surgery; except for the correction of birth defects, accidental injuries or traumatic scars, or reconstructive surgery to correct deformities resulting from specified diseases or medically necessary surgery;
3. Hospital admissions that are not medically necessary, such as admissions that are principally for diagnostic evaluation, or physical therapy, or reduction of weight by diet control.
4. Custodial care or domiciliary care which does not require definitive medical or nursing services for an illness or injury.
5. Care for occupational injury or disease or care obtainable without cost from government agencies or through the facilities of the employer.
6. Routine physical, premarital or pre-employment examinations.
7. Items such as blood, durable medical equipment, prosthetic and other appliances, and ambulance service unless specifically mentioned as being covered in this proposal.

## **SECTION 2**

### **MASTER MEDICAL EXPENSE BENEFITS**

The City's coverage for master medical benefits shall be 80% of the usual and customary fees for out-patient services provided by the plan after the employee pays for the first \$175 of cost per person or \$350 per family per year. After an employee has out of pocket expenses over \$1,000 for an individual, or \$2000 for a family in any calendar year, 100% of the eligible expenses are covered. The life-time maximum benefit is \$1,000,000.

Out-patient treatment for substance abuse, psychiatric and nervous disorders shall be limited to 50% of reasonable fees with an annual limit of \$2,000 per year and a life-time limit of \$5,000. (This is in addition to the basic benefit). The plan's maximum is \$15,000 for one year and \$30,000 for two or more years for combined in-patient and out-patient psychiatric services.

#### **A. AMBULANCE:**

If a member of the plan is transported to a medical facility due to an accidental injury or medical emergency or if they or their eligible dependents are transferred from one medical facility to another at their doctor's recommendation, the plan will pay for such ambulance service under the master medical benefit.

#### **B. ITEMS NOT COVERED BY MAJOR MEDICAL:**

The plan does not cover the following types of expenses, disabilities or care:

- Extended benefits are not available for pulmonary tuberculosis or mental disorders.

- Routine dental care such as fillings, extractions, bridgework, braces, root canals and impacted wisdom teeth.
- Eyeglasses, routine eye examinations, eye refractions, hearing aids and the fitting of hearing aids or eyeglasses.
- Routine physical examinations and related tests.
- Cost of transportation that exceeds ambulance benefit level.
- Personal comfort items while hospitalized, including but not limited to, television and telephone.
- The portion of room charges which exceeds the hospital's ward rate.
- Surgical procedure, treatment or hospital confinement primarily for beautification.
- Expenses for work-related injuries or disabilities (these are covered by Workers' Compensation).
- Expenses for care of injuries or sickness due to war or war-related acts.
- Any treatment or service not prescribed by a physician.
- Screening or other procedures not necessary for diagnosis and generally accepted therapy.
- Any surgery or medical care or service furnished by any facility contracted for or operated by the United States Government or by any other governmental unit for medical care or treatment unless a charge is made which the insured is legally required to pay.
- Expenses for the treatment of nervous, mental, or substance abuse disorders that exceed the basic benefit level.
- Any fees that exceed the reasonable and customary fee determination.
- Purchase of wheel chair, hospital bed, artificial respirator, other durable medical equipment.
- Care in convalescent or nursing homes.

## **SECTION 3**

### **PRESCRIPTION DRUG PLAN**

- A. Coverage – The prescription drug benefit covers the cost of most prescription drugs after the employee pays a \$5 co-pay for generic drugs, or \$15 for brand name drugs.
- B. A list of preferred providers for prescription drugs which an employee must use to obtain the full benefit is attached.
- C. **COVERED DRUGS:**
  1. Federal Legend Drugs
  2. State Restricted Drugs
  3. Compounded Medication
  4. Insulin

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D. The plan will require a pharmacy to use generic drugs, if available, unless specifically directed by the prescribing physician based on medical necessity not to do so.

**E. ITEMS NOT COVERED:**

Certain items are not covered by the prescription drug program. Among these are:

- The charge for any take home drug.
- Any charge for a contraceptive medication, even if such medication is a prescription legend drug, and any charge for therapeutic devices or appliances, regardless of their intended use.
- Therapeutic devices or appliances (hypodermic needles, support garments and other non-medicinal substances).
- Drugs or medicines supplied to the covered individual by a prescribing physician or dentist.
- Cosmetic or beauty aids, dietary supplements and vitamins.
- Immunizing agents, injectables, blood or blood plasma or medication prescribed for parental administration, except insulin.
- Any drug labeled "Caution – Limited by Federal Law to Investigational Use" or any experimental drug.
- Any charge for administration of covered drugs.
- The charge for more than a 34-day supply of a covered drug except that benefits will be payable for 100 unit doses (e.g., tablet or capsule, etc.) of specified maintenance drugs unless provided by a mail order pharmaceutical provider.
- The charge for any prescription order refill in excess of the number specified by a physician or dentist, or any refill dispensed after one year from the date of the original prescription order.
- The charge for any medication for which the employee or dependent is entitled to without charge from any municipal, state or federal program of any sort whether contributory or not except Title XIX of Social Security Amendments of 1965 (Public Law 89-97; 89<sup>th</sup> Congress, First Session).

## **SECTION 4**

### **PREFERRED PROVIDER ORGANIZATION AND HEALTH MAINTENANCE ORGANIZATIONS**

The health maintenance organizations and preferred provider organizations currently being offered to employees are as follows:

**Blue Care Network**  
**Health Alliance Plan**  
**Blue Cross Community Blue PPO**  
**Total Health Care Plan**

Benefits provided by these carriers are as follows:

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<b>BENEFIT</b>	<b>EXTENT OF COVERAGE</b>
Service in hospital	Full coverage
Human Organ transplants	Covered, except for experimental
Emergency Care – Medical	Full coverage-following \$75 employee co-pay, if applicable
Emergency Care – Accidents	Full coverage
Routine Medical Services	Full coverage-A \$10 office visit co-pay may be applicable
Maternity Services Provided by Doctor	Full coverage
Prescription Drugs	Full coverage (employee responsible for \$5 co-pay for generic, or \$15 for brand name drugs)
Diagnostic and Therapeutic Procedures	Full coverage
Immunizations	Full coverage
Family Planning	Full coverage for most services
Mental Health Care	Varies with carrier
Alcoholism/Drug Abuse	Varies with carrier
Skilled Nursing Care (not in hospital)	Nursing home care – 730 days
Appliances and Prosthetic Devices and Durable Medical Equipment Devices	Full coverage

Prior to the annual enrollment each year a comparison of coverages provided by each of the plans will be provided to members of the Union.

## **SECTION 5**

### **DENTAL CARE PLAN**

#### **A. COVERAGES:**

Class I benefits 75% of usual and customary fees.  
 Class II benefits 50% of usual and customary fees.  
 Class III benefits 50% of usual and customary fees.  
 Orthodontics – 50% of usual and customary fees not to exceed \$1,000 maximum life benefit per person covered by the plan.  
 Annual maximum of Class I, II, and III benefits is \$1,000 per year.

#### **B. ITEMS NOT COVERED:** Dental benefits are not available for the following types of expenses or care:

- Treatment or supplies furnished on account of a dental defect which arises out of, or in the course of, any occupation for wage or profit;

- Any loss sustained as a result of declared or undeclared war, or any act thereof, or of military or naval service of any country;
- Dental procedures received from a dental department maintained by a mutual benefit association, labor union, trustee, or other similar group;
- Any expense for dental procedures or supplies to the extent that payment is received from any group policy or prepayment plan;
- Any treatment which is performed for cosmetic purposes;
- Treatment by other than a legally qualified dentist, except charges for dental prophylaxis performed by a licensed dental hygienist under the supervision and direction of a dentist, or licensed dental practitioner; or in connection with dentures, bridgework, crowns, or prosthetic devices for:
  1. Expenses for prosthetic devices started prior to the effective date of coverage;
  2. Expenses for replacement made less than five years after and immediately preceding placement or replacement which was covered by this plan or the predecessor plan;
  3. Expenses for extension of bridges or prosthetic devices previously paid for by the plan except for expenses incurred for new extended areas;
  4. Loss or theft:
    - a. Temporary restorations, local anesthetics, and/or bases;
    - b. Expenses for root canal treatments and/or apicoectomies when previously paid; these are payable only once per tooth;
    - c. Orthodontic benefits are not available for the member and spouse or dependent children over age 19 (even if a full-time student).

**C. PRE-DETERMINATION OF BENEFITS (EXCLUDES CAPITATION PLANS):**

The following procedures will require pre-determination by the plan:

1. Prosthodontics
  - a. Inlays
  - b. Onlays
  - c. Crowns
  - d. Space Maintainers
  - e. Bridges
  - f. Removable Full or Partial Dentures

2. Periodontics
  - a. Subgingival Curettage
  - b. Surgical Periodontics

3. Oral Surgery

All oral surgical procedures with the exception of four (4) or less simple extractions.

4. Orthodontics

All services

D. Currently the City is offering Den Cap and Golden Dental Centers as capitation dental carriers. These Plans have smaller co-pays and deductibles in most areas than our traditional plan. However, you must select your Dentist from their network.

## **SECTION 6**

### **EYE CARE PLAN**

A. **COVERAGE:** The plan will pay for an eye examination and glasses once every two years. Co-op Optical Company and Heritage Optical Company are the current providers of this service. This coverage is only available at one of these two firms. The employee may be required to make co-payments for designer frames, special lenses, and contact lenses.

B. **ITEMS COVERED UNDER THE PLAN:**

- Eye Examination
- Frames: No charge for frames equal to or less than \$75
- Eye Glass Lenses:
- Single vision
- Bifocal covered through Executive Level
- Tint: One (1) single color
- Contact Lenses: Exam and Lenses \$90 allowance (in lieu of eye glass service)
- Progressive Myopia: (Rapidly changing near sighted vision) Through age 19 for dependent children; annual exam and new lenses with a prescription change.
- Miscellaneous:
- Six month warranty against breakage on in-program frames; 1-year extension for \$10 20% discount on additional glasses after 1<sup>st</sup> pair secured through benefit plan
- Scratch Cote: Prism (if required) (front only) on in-program lenses
- Oversize: On in-program lenses

C. **ITEMS NOT COVERED:**

Benefits are not payable for the following types of care or expense:

- Procedures or supplies furnished due to a visual defect which arises out of, or in the course of, any occupation for wage or profit;
- Vision care services resulting from declared or undeclared war, or any act thereof, or military or naval service of any country;
- Vision care services or supplies furnished by or at the direction of the United States Government or any agency thereof;
- Vision care services or supplies received from a medical department maintained by a mutual benefit association, labor union, trustee or other similar group;
- Vision care services or supplies which are payable or furnished by any other group policy or prepayment plan;
- Any medical or surgical treatment of the eye;

- Sunglasses, plain or prescription, goggles, photo chromic lenses, or tinting, except as specified in B above; or safety lenses, except as provided in the MOU RE: Skilled Trades;
- Orthoptics, vision training or aniseikonia;
- Trifocal;
- Repair of any kind, except as specified in paragraph B above;
- Loss or theft; and
- Vision expenses incurred by a dependent child after attaining age 19.

## **SECTION 7**

### **PENDING CHANGES**

During the term of the contract the joint Union/Management Health Care Committee will be examining additional alternatives to control health care cost. Some of the alternatives being considered as of the date of this agreement are as follows.

#### **A. CONTROL PROCEDURES**

The plan will establish procedures to guard against misuse. This shall include the audit of claims to insure their legitimacy and the collection of health care cards from terminating employees. Other control procedures may be instituted by the administrator.

#### **B. EMPLOYEE EDUCATION PROGRAMS**

The plan will develop a booklet which will describe the benefits and procedures to be followed in using the plan. They will continue to provide educational material to plan members which will help them to become more familiar with methods to contain health cost.

#### **C. PRESCREENING PROGRAMS**

The plan will develop a prescreening program for employees to help them identify health problems before they become critical. The plan will develop a delivery system for the program which will be convenient for the members and also will guarantee the confidentiality of the program.

#### **D. MATERNITY CONFINEMENT**

The plan may include an incentive for members who elect to shorten their hospital confinement for maternity purposes or use of birthing centers. The incentive shall be based on the standard number of days allowed for in-patient maternity confinement in the hospital admission pre-certification program. In the event that birthing centers are less expensive than inpatient hospital confinement, an incentive plan will be developed to encourage the use of them.

**E. BILLING AUDITS**

Employees are encouraged to review their hospital and doctor bills for accuracy. The Health Care Committee will agree on a remuneration "finder's fee" for significant discrepancies discovered.

**F. EMERGENCY CLINICS**

A list of non-hospital based clinics which will provide non-emergency 24-hour medical services will be established. Employees should use these facilities for non-life threatening medical emergencies.

**G. PRESCRIPTION DRUGS**

The Plan may seek an administrator for prescription drug coverage which may be different from the administrator of the hospital-medical-surgical plan.

## **SECTION 8**

### **City Alternative Health Care Plan**

- A. This "City Alternative Health Care Plan" is conditioned upon the City achieving the specific cost saving objectives professionally-estimated and calculated to result from the implementation of all of the features contained in this proposal and based on beginning at the of the FY 2006 – 2007 benefit year. The health care benefit plan changes specified in the attached document will be effective, July 17, 2006. The corresponding open enrollment for the purposes of implementing this "Alternative Health Care Plan" will begin on July 31, 2006, and conclude on September 6, 2006.
- B. Contribution Structure: Effective July 17, 2006, the employee's contribution towards the component premiums (i.e., one person, two persons, family), for the BC PPO plan shall be capped at 10% of the monthly premium, and for all HMO plans capped at 20% of the monthly premium. If the Blue Cross/Blue Shield Traditional plan as modified by the new plan design, continues to be offered as an option, it will be offered under the current premium sharing arrangement.
- C. Effective with the Family Continuation Verification Period for the coverage plan year beginning July 17, 2006, in addition to the existing family continuation requirements, employees insuring family continuation dependents must also provide proof the dependent is enrolled in an accredited school as a full-time student in order for that dependent to be eligible for continued coverage.
- D. Employees insuring sponsored dependents under any plan shall continue to pay the entire premium for this coverage.
- E. Effective with the coverage plan year that begins on or after July 1, 2006, in order to be eligible for coverage under all City of Detroit health care plans, all active employees and

their dependents who are eligible for Medicare due to certain medical conditions as defined by Medicare must enroll in Medicare Parts A and B.

Such enrollment in Medicare shall not result in any reduction in benefits or additional cost to the employee, in that the employee shall be reimbursed that amount paid for Medicare after submission of required proof of payment (This benefit does not apply to retirees or dependents covered under the City retiree's health care contract. Currently, all retirees and their dependents who are eligible for Medicare regardless of age must enroll in Medicare Parts A and B at their own expense to be eligible for continued coverage, and this provision shall remain unchanged and applicable to all persons who retire in the future.)

F. Effective with the implementation of the new HR/Payroll and Benefit System:

1. Health care and life insurance coverage start and end dates shall be as follows:

**Hospitalization:** Coverage begins on the first day of the first full pay period, and ends on the last day of the month that employment ends.

**Dental:** Coverage begins on the first of the month following the employee working six months, and ends on the last day of the month that employment ends.

**Optical:** Coverage begins on the first of the month following 60 days of service, and ends on the last day of the month that employment ends.

**Life Insurance and Death Benefit:** Coverage begins on the first day of the first full pay period, and ends on the last day of the month that employment ends.

2. **Supplemental Life Insurance Coverage:** Employees may opt for additional coverage up to either their actual salary or double their actual salary, rounded up to the nearest thousand. This would replace the Option 1 and Option 2 schedules for additional life insurance found in the Death Benefit and Life Insurance article of the Master Agreement.

3. **Opt-Out Program:** Employees will receive a monthly stipend.

4. **Pre-Tax Medical Premiums:** The employee's share of medical premiums will be shown and paid on a pre-tax basis.

5. **Employee Payroll Deductions:** Payroll deductions will be taken out equally during every pay cycle.

In addition to the above noted provisions, the parties will continue to work collaboratively toward establishing cost saving measures for medical, dental, optical and life insurance plans as well as resolve issues that may arise with the implementation of the new HR/Payroll and Benefit System.

<b>City of Detroit Alternative Health Care Plan Design BCBSM PPO Plan</b>				
Plan Design	In-Network Benefits		Out-of-Network Benefits	
	Current Plan	Alternative Plan	Current Plan	Alternative Plan
<b>General Plan Information</b>				
Annual Deductible/Individual	\$0	\$175	\$250	\$425
Annual Deductible/Family	2x individual deductible	2x individual deductible	2x individual deductible	2x individual deductible
Coinurance (Outpatient only)	100%	90%	80%	70%
Office Visit/Exam	\$5 copay	\$15 copay, then 100%	D&C	D&C
Outpatient Mental Health/Substance Abuse	90%/50%	\$90%/50%	80%/50%	70%/50%
Annual Out-of-Pocket Limit/Individual	None	\$1,000	\$1,000	\$2,000
Annual Out-of-Pocket Limit/Family	None	\$2,000	\$2,000	\$4,000
Inpatient Hospitalization	100%	100%	80%	70%
Emergency Room (copay waived if admitted)	\$50 copay	\$75 copay, then 100%	\$50 copay	\$75 copay, then 100%
Urgent Care Facility	100%	\$10 copay, then 100%	D&C	D&C
Hospital Admission Deductible	None	None	None	None
<b>Prescription Drug Benefits Retail</b>				
Generic	\$5	\$5	75% less copay	Not covered
Brand (Single source/Formulary)	\$10	\$15	75% less copay	Not Covered
Brand (Multi source/Non-formulary)	\$10	\$15	75% less copay	Not Covered
Number of Days Supply	30 days	30 days	30 days	30 days
<b>Mail Order</b>				
Generic	\$5	\$10	Not covered	Not Covered
Brand (Single source/Formulary)	\$10	\$30	Not covered	Not Covered
Brand (Multi source/Non-formulary)	\$10	\$30	Not covered	Not covered
Number of Days Supply for Mail Order	90 days	90 days	90 days	n.a.

<b>City of Detroit Alternative Health Care Plan Design BCN, HAP and THC HMO Plans</b>		
<b>Plan Design</b>	<b>Current Plan</b>	<b>Alternative Plan</b>
<b>General Plan Information</b>		
Office Visit Copay	None	\$ 10 Copay
Inpatient Admission Copay	None	None
Emergency Copay (Waived if admitted)	None	\$ 75 Copay, then 100%
Urgent Care Copay	None	\$10 Copay
Outpatient MH/SA Copay	None	\$10 Copay
<b>Prescription Drug Benefits Retail</b>		
Generic	\$3	\$5
Brand (Single source/Formulary)	\$3	\$15
Brand (Multi-source/Non-Formulary)	\$3	\$15
Number of Days Supply	30 days	
<b>Mail Order</b>		
Generic	\$3	\$10
Brand (Single source/Formulary)	\$3	\$30
Brand (Multi-source/Non-Formulary)	\$3	\$30
Number of Days Supply for Mail Order	90 days	90 days

<b>City of Detroit Alternative Health Care Plan Design BCBSM Traditional Plan</b>		
Plan Design	Current Plan	Alternative Plan
<b>General Plan Information</b>		
Annual Deductible/Individual	\$50	\$175
Annual Deductible/Family	2x individual deductible	2x individual deductible
Office Visit/Exam	80%	80%
Outpatient Mental Health Substance Abuse	100% first 6 visits, then 50%	100% first 6 visits, then 50%
Annual Out-of-Pocket Limit/Individual	\$1,000	\$1,000
Annual Out-of-Pocket Limit/Family	\$2,000	\$2,000
Lifetime Plan Maximum	\$1,000,000	\$1,000,000
<b>Inpatient Hospital Services</b>		
Inpatient Hospitalization	100%	100%
Semi-Private Room & Board; Including Services and Supplies	100%	100%
Emergency Room (co-pay waived if admitted)	100%	\$75 copay then 100%
Urgent Care	100%	80%
Hospital Admission Deductible	None	None
<b>Prescription Drug Benefits</b>		
Retail		
Generic	\$3	\$5
Brand (SingleSource/Formulary)	\$3	\$15
Brand (MultiSource/Non-Formulary)	\$3	\$15
Number of Days Supply	30 days	30 days
<b>Mail Order</b>		
Generic	\$3	\$10
Brand (SingleSource/Formulary)	\$3	\$30
Brand (MultiSource/Non-formulary)	\$3	\$30
Number of Days Supply for Mail Order	90 days	90 days

## **AMBULATORY PROCEDURES**

<b>PROCEDURE CODE</b>	<b>ENGLISH DESCRIPTION</b>
0145	Excision of pilonidal cyst of sinus, simple
0454	Excision of cyst, fibroadenoma or other benign tumor, aberrant breast tissue, duct lesion of nipple lesion (except 0465-0471) bilateral
0465 (T)	Mastectomy for gynecomastia, unilateral
0521	Biopsy, deep bones (e.g. vertebral body femur)
0522	Biopsy, excisional, bone superficial (e.g., ilium, sternum, ribs, spinous process, trochanter of femur)
0588	Excision of calcaneal spur
1342	Arthroplasty, metatarsophalangeal joint, other than hallux, with silastic implant
1601	Muscle biopsy, deep
2060	Infraction of turbinates, unilateral or bilateral
2085	Anthrotomy, intra nasal, bilateral
2790	Biopsy or excision of lymph node
2791	--deep cervical mode
3740 (T)	Repair, inguinal hernia, under age 5, with or without hydrocelectomy, bilateral
3745 (T)	Repair, inguinal hernia, under age 5, with or without hydrocelectomy, bilateral
4040	Cystourethroscopy with biopsy, initial
5620 (T)	Extra ocular muscle surgery (resection, recession, advancement, etc.), one muscle
5696 (T)	Slepharoplasty: plastic repair of eyelid with or without graft
0994	Fracture, humerus, surgical neck, closed reduction
1493	Dislocation, elbow, closed manipulative reduction, without anesthesia
3163	Esophagoscopy, diagnostic with biopsy
3165	--with dilation, direct
3190	Dilation of esophagus by sound or bougie, indirect, initial
3220	Gastroscopy, diagnostic
3417	Colonscopy (by fiberoptic instrument), transverse colon
3696	Peritoneocentesis: abdominal paracentesis, initial
5155	Spinal puncture, lumbar diagnostic